STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IN005354	A. BUILDING: _____ B. WING _____	R 04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIESS COMMUNITY HOSPITAL HOME HEALTH	MEMORIAL AT 14TH ST DAVIESS COMMUNITY HOSPIT WASHINGTON, IN 47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments This was a revisit for the State home health re-licensure survey completed on 3-17-14. Survey Date: 4-23-24 Facility #: 005354 Medicaid Vendor #: 100264920A Surveyor: Vicki Harmon, RN, PHNS Eight (8) deficiencies were found to be corrected during this survey. Daviess Community Hospital Home Health was found to be in compliance with the Indiana rules for home health agency licensure 410 IAC Article 17. Quality Review: Joyce Elder MSN, BSN, RN April 24, 2014	{N 000}		